DWS-ESD 61LT
Rev. 11/2010

State of Utah
Department of Workforce Services

MEDICAL APPLICATION FOR LONG-TERM CARE

PLEASE USE A BLACK BALL POINT PEN TO COMPLETE FORM

Case#: _____ PID#: _____

Answer the questions on this form to apply for Nursing Home or other medical institution or Medicaid Waiver programs. The questions refer to the person who needs the help. Questions 18, 19, and 20 do not apply to Waiver applicants. **If you need help completing this form, please let us know.**

If you are only asking for an Assessment of Assets for a Married Couple, check here: ☐

Your Name: _____

Street Address: _____
Street City State Zip

Mailing Address: _____
Street City State Zip

Home Phone _____ Cell/Other Phone _____

E-mail: (optional) _____

Who Lives In Your Home?

List the people who are living in your home while you are receiving nursing home or other long term care or care through a waiver program.

Name	Sex	Relationship	Birth Date	SS# or Legal Alien ID*	Marital Status
❶		Self			
❷					
❸					
❹					

* Social Security Number and Citizenship information are only needed for the people applying for benefits.

1. Are you a Utah resident? ..... ☐ Yes ☐ No
   If no, please explain: _____
2. Are you a U.S. citizen or qualified alien? ..... ☐ Yes ☐ No
3. When do you want the Medicaid help to begin? _____
4. Are you living in a nursing home/institution? If yes, name of facility _____
   Give the date you entered. _____
   Where did you live before you entered the facility? _____
   Have you lived in another facility for more than 30 continuous days? ..... ☐ Yes ☐ No
   If yes, which one? _____ Date of entry: _____ Date of discharge: _____
   Has your marital status changed since you entered? ..... ☐ Yes ☐ No
   Did you enter the facility from the hospital? ..... ☐ Yes ☐ No
   If yes, which hospital? _____
   Date you entered the hospital? _____ Date discharged? _____
   Do you intend to return home? ..... ☐ Yes ☐ No
   If yes, ☐ 90 days, ☐ 6 months or less (Dr statement needed), or ☐ more than 6 months.
5. Do you want someone to act as an authorized representative and have access to the information regarding your case? ..... ☐ Yes ☐ No
   If yes, please list name, address and phone number: _____
   Does this person have power of attorney, legal guardianship, etc. for you? ..... ☐ Yes ☐ No

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6. Are you a Veteran of the U.S. Armed Forces or have you been claimed as a dependent of a Veteran?
List name of Veteran _____ Relationship _____
Did the Veteran serve in wartime?..... ☐ Yes ☐ No
Has the Veteran ever received V.A. benefits?..... ☐ Yes ☐ No
Does the Veteran have a service connected disability? ..... ☐ Yes ☐ No
Is the Veteran deceased?..... ☐ Yes ☐ No
If yes, was the Veteran in the Armed Forces at the time of death?..... ☐ Yes ☐ No
If yes, date of death: _____

7. **Assets** - List vehicles in the next section. List any assets owned by you and your spouse. Include anyone else's assets in which you or your spouse are a joint owner, signer, or trustee. Assets are things like bank accounts, cash, homes or real estate, IRA or 401K, stocks/bonds, notes, annuities, livestock, water shares, oil/mineral rights, life insurance, funeral plans, burial spaces, etc. List vehicles in the next section.

Type of Asset	Owner(s)	Account #	Value	Amount Owed

Vehicles - (Car Truck/Van Other Vehicle Motor Home Motor Cycle Snowmobile Boats/Motors etc.)

Type of Vehicle	Make	Model	Year	Licensed Yes/No Lic. # / State	Owner/ Joint Owners	Amount Owed	Current Value

In the past 60 months, did you or a spouse own property which was NOT in the state of Utah?…….. ☐Yes ☐No
If yes, what state:_____ Property Value:_____ Equity Value:_____

In the past 60 months, did you or a spouse own property in the state of Utah? ……. ☐Yes ☐No
If yes, property value: _____ Amount owed on property: _____

8. Does anyone owe money to you or your spouse, such as a sales contract?…. ..... …… ..... ☐ Yes ☐ No
If yes, please explain: _____

9. Have you sold or given away any assets you used to own in the last 60 months? ..... ☐ Yes ☐ No
If yes, please explain:_____
_____

10. Do you have a trust?..... ☐ Yes ☐ No
Have you transferred anything into or out of the trust in the last 60 months? ..... ☐ Yes ☐ No
If yes, please explain:_____
_____

11. **Income** - List all income received by you or your spouse. Include income from, Social Security, SSI, Civil Service, Railroad Retirement, Veterans Benefits, retirement income, pensions, disability income, earnings, self-employment, unemployment, child support, alimony, church assistance, rental income, cash gifts, interest income, income from investments, inheritance or settlement income, etc.

		Income Type	Amount of Income	How Often Paid
Self	❶			
	❷			
	❸			
Spouse	❶			
	❷			
	❸			

12. Do you expect any changes in you or your spouse"s income? ..... ☐ Yes ☐ No
    If yes, explain: _____

13. Has anyone applied for any type of income that is not yet being received? ..... ☐ Yes ☐ No
    If yes, explain _____

14. If you are not currently employed, when did you last work for pay? _____ Your spouse? _____

15. Does any person or organization give you money to pay expenses? ..... ☐ Yes ☐ No

Other Information

16. Do you live at home or have a spouse or other dependent at home? ..... ☐ Yes ☐ No
    Please list the following:
    Rent or Mortgage $_____
    Utilities (electric, heat, telephone) $_____
    Second Mortgage $_____
    Property Taxes if not included $_____
    Trailer Space Rental $_____
    Condo Fee $_____
    Homeowners Insurance $_____

17. Does anyone help you or your spouse or dependent pay these expenses? ..... ☐ Yes ☐ No
    If yes, give name and relationship _____

18. Is Medicare paying for any of your days in the nursing home? ..... ☐ Yes ☐ No
    If yes, which days? _____

19. Is Veteran's Administration paying for any of your days in the nursing home? ..... ☐ Yes ☐ No
    If yes, which days? _____

20. Do you have any other help in paying for the nursing home? ..... ☐ Yes ☐ No
    If yes, please explain _____

21. Do you want help with any unpaid medical bills? ..... ☐ Yes ☐ No

22. If you have medical insurance, how much do you pay? _____ How often do you pay? _____
    When is the next payment due? _____ Who pays the premium? _____
    Does the insurance include your spouse? ..... ☐ Yes ☐ No

THIRD PARTY AND INSURANCE INFORMATION

Name: Birth date: Case#

1. Does anyone in your home currently have health insurance including Medicare?..... ☐ Yes ☐ No
   If you answered yes, complete Section 1.

2. Has anyone had Insurance that has ended in the past 6 months?..... ☐ Yes ☐ No
   If you answered yes, enter the information in Section 2.

3. Do you have insurance available which you have not enrolled in?..... ☐ Yes ☐ No
   If you answered yes, complete Section 2.

4. Does someone in your home have a major medical need*?..... ☐ Yes ☐ No
   Who has the medical need?_____ What is the medical need?_____
   If yes, do you have: 1. Insurance available which you have not purchased?..... ☐ Yes ☐ No
   2. Insurance that has ended in the past 60 days?..... ☐ Yes ☐ No
   *Pregnancy is considered a major medical need. If you answered yes, enter the information in Section 2.

5. Have you or any household member been injured in an accident or assault?..... ☐ Yes ☐ No
   If you answered yes, complete Section 3.

6. Is any other person required to pay medical expenses for anyone in your household?..... ☐ Yes ☐ No
   If yes, person's name _____ Phone #: _____

7. Has anyone in your household ever served in the military?..... ☐ Yes ☐ No
   Name:_____ Dates of Service: _____

Section 1 - **Insurance Information** (If you answered NO to question 1, do not complete this section)

Name of Insurance Company:_____ Phone #:_____
Address of Insurance Company: _____ Group #: _____
Policyholder Name: _____ Policy #: _____
Policyholder Date of Birth: _____ Policyholder Social Security Number: _____
If insurance is through an employer, list employer name and phone _____
Premium $_____ Date Due:_____ How Often? _____
Names of Individuals Covered:_____
Medicare Number (if applicable)_____

Name of 2nd Insurance Company:_____ Phone #:_____
Address of Insurance Company: _____ Group #: _____
Policyholder Name:_____ Policy #: _____
Policyholder Date of Birth: _____ Policyholder Social Security Number: _____
If insurance is through an employer, list employer name and phone: _____
Premium $_____ Date Due:_____ How Often? _____
Names of Individuals Covered (if not listed on the insurance card):_____

Section 2 - **Buy-Out/PCN Information (complete if you answered yes to #4 above)**

Name and Phone of Insurance Company_____
Policyholder Name:_____ Policy #: _____
Employer Name & Phone (if applicable): _____
If not through an employer, how is insurance available?_____

Section 3 - **Accident or Assault Information** (If you answered NO to question 5, do not complete this section)

Please check the type of incident: ☐ automobile ☐ assault ☐ work-related ☐ slip/ fall ☐ dog bite
☐ medical malpractice ☐ other, please explain_____
Name of person(s) injured:_____
Date of incident:_____ Was a police report filed? ❑ Yes ❑ No
Police department: _____ Police Report Number: _____
Name of Attorney: _____ Phone number: _____

☞BEFORE YOU SIGN THIS APPLICATION, BE SURE YOU UNDERSTAND THIS INFORMATION☜

*The State of Utah (the State) references below include the Utah Department of Health, the Department of Workforce Services and/or the Office of Recovery Services.

- I assure that all household members applying for medical coverage or reimbursement are U.S. citizens or aliens in lawful immigration status, unless I am requesting emergency medical assistance only. I understand that I do not have to report citizenship information for household members who are not applying for coverage or reimbursement. The State will verify alien registration numbers with the U.S. Citizenship and Immigration Service (USCIS). The State will not report undocumented household members to USCIS.

- The State does not discriminate on the basis of race, ethnicity, religion, gender or disability.

- I must follow the medical assistance program rules. My spouse and/or children, as applicable, also must follow these rules.

- If I receive a medical card, I will allow only the people named on the medical card to use the card.

- If the State pays for my medical care, I assign to it my rights to payments from any third party and to benefits for medical services. I will give to the State any money I collect from an insurance policy or from someone required to pay for my medical expenses. I authorize payment directly to the State and will hold harmless any party making payment to them.

- I agree to cooperate with the State of Utah to establish medical support for my family and in pursuing any third party responsible for medical expenses. I agree to cooperate with the State of Utah to establish and collect alimony and child support for my family unless I have good cause.

- The medical benefits I receive are limited to those described in the Provider Manual established for the program, as applicable. I understand these manuals may be amended without my consent or consideration.

- The benefits I am eligible to receive may be changed without my knowledge or consent. I understand I am responsible for any co-pays to providers at the time of medical services unless I am exempt from these co-pays.

- I authorize the State to give health care providers information about my eligibility for medical benefits. The State may exchange information with my health insurance carrier and/or my employer for the period I receive benefits from the program.

- The State has the right to recover from my estate all money spent to pay my medical bills if I receive Medicaid at any time while I am 55 years of age or older. Medicare premiums, deductibles and co-payments paid under the Medicare Cost-Sharing programs are excluded from Estate Recovery.

- I give permission for ANY INFORMATION provided to be verified when I apply and after I receive benefits. My medical benefits may be reduced, denied, or stopped due to reported information. I understand that failure to report changes and any false information given on this application, or subsequently provided, may result in prosecution for fraud. If I receive benefits that I am not eligible to receive, I will be responsible for repaying the benefits received.

- I understand that I may ask for a fair hearing if I disagree with the decision made on this application.

- I have been given a copy of the Rights and Responsibilities and Change Reporting Requirements.

**** *I (print name) _____, read or had read to me the statements on this page. I understand those statements. Under penalty of perjury, I swear that the answers I have given on this application are complete and correct. I am the person represented by the signature on this document.*

Signature or Mark of the Applicant	Signature of the Spouse or Representative	Date

VOTER REGISTRATION INFORMATION

If you are not registered to vote where you live now, would you like to apply to register to vote here today? ☐ Yes ☐ No

If you do not check either of these boxes, we will assume you have decided not to register to vote at this time. You may fill out the application form in private. If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. Choosing to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency. If you believe that someone has interfered with your right to register, your right to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with Lt. Greg Bell, State of Utah, 203 State Capitol Building, Salt Lake City, UT 84114.

****Please tear off the following pages for your information.****

Your Rights and Responsibilities

You have the right to:

- Apply or reapply any time you wish for any medical program. Applications for PCN and UPP are only accepted during open enrollment periods. If you need help, someone will help you apply.
- Receive a notice that we have either approved or denied your application and the reasons for the decision.
  For medical assistance, we have 30 days to process your application, or 90 days if you claim to be disabled, unless you need more time.
- Be notified explaining why we reduce, stop or hold your assistance. In most instances we must mail the notice 10 days before we do this.
- Do the following things if you do not agree with decisions made regarding your case:
  A. Talk to your worker. Make sure you are not misunderstanding each other.
  B. Talk to your worker's supervisor.
  C. Talk to Constituent Services. Salt Lake 801-538-6417 or call toll-free 1-877-291-5583.
  D. Request a Fair Hearing within 90 days of the decision or within 10 days to receive benefits while the hearing is held. If you were denied disability status, you may also ask for a reconsideration as part of the fair hearing. If SSA denied your disability, you would have to go through their appeal process.
  E. Request legal representation regarding your fair hearing. You may be entitled to free legal assistance from Utah Legal Services. In Ogden, 801-394-9431; Salt Lake, 801-328-8891. The toll free number is 1-800-662-2538. You may also receive a referral for legal advice from the Salt Lake Lawyer Referral at 531-9075.
- Look at information in your case. Information about you and your case is confidential. Information may be given to other agencies to administer a program to help you.

Your Responsibilities:

Verify Information- The Social Security Act (U.S.C. 1320 b - 7 (a) (1) requires that you give us a Social Security number for each household member who wants medical assistance. If you do not have a number, you must prove you have applied. You may be eligible for assistance while you are waiting to receive a number. If you are applying only for emergency Medicaid, you do not have to have a Social Security Number.

Your Social Security number will be used with the State Income and Eligibility Verification System to make sure that your household is eligible for federal assistance programs. Computer matching, program reviews, and audits will be done with DWS, U.S. Citizenship and Immigration Services (USCIS), Social Security, and Internal Revenue Service records. We may also do inquiries to banking and loan institutions and any other organizations or individuals who may have eligibility information about your household. You must provide proof showing that you are eligible for assistance. The Department will not report undocumented household members to USCIS.

Children enrolled in Medicaid are automatically enrolled in the Utah Statewide Immunization Information System (USIIS). If you do not want your children enrolled in this system, you must call the USIIS HelpLine at 801-538-6872 or the Immunization Hotline at 1-800-275-0659.

Cooperate
You must cooperate in any review of your case by Quality Control, Recovery Services, and the Bureau of Eligibility Policy. You must also cooperate in providing information about any other sources of medical payments and obtaining medical support. If you feel you could be harmed by giving this information, you can request a ‘good cause’ claim. Your worker can explain this procedure.

You and your household must also obey the medical assistance program rules.

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State of Utah
Department of Workforce Services

CHANGES YOU MUST REPORT

Please remember that you are required to report changes in your situation within 10 days of the day you learn of the change. Do not delay reporting changes. Changes can affect the amount of your benefits or your eligibility. If you receive more than you are eligible to receive, you will have to repay that amount. Changes you report for one program may affect your eligibility for other programs.

YOU MUST ALWAYS REPORT:

If you move.

If your total household income (before anything is taken out) becomes more than: $_____ per month .

AND if you receive **CASH ASSISTANCE** you must also report**:**

- If you only have one child receiving cash assistance and that child moves out of your home.

AND If you need **FOOD STAMPS** and you are able-bodied between the ages of 18-49 with no children living in your household you must also report:

- If your employment hours fall below 20 hours per week.

AND If you receive **CHILD CARE ASSISTANCE** you must report:

- If a parent, stepparent, spouse or former spouse moves into the home, getting married, a child receiving child care moves out of the home.
- If a parent's and/or child's school schedules change so that child care is no longer needed during the hours of approved employment and/or training activities.
- No longer in an approved training or education program.
- Not meeting minimum work requirements. This includes termination of employment. (Single parents must be employed at least 15 hours per week. In two-parent households, one parent must work at least 15 hours per week while the other parent works at least 30 hours per week.)
- If you change your child care provider.

AND If you receive **MEDICAL ASSISTANCE** you must report:

- Change of an income source.
- Change of more than $25 in gross monthly income.
- Receipt of a lump sum from any source:
  - Insurance payments
  - Accident or injury awards
- Change in assets:
  - Gaining or losing a vehicle
  - Opening a bank account
- Change of more than $25 in total allowable deductions.
- Change in health insurance.
- Change in household size, living arrangements or marital status.
- Change in the type of residence such as entering or leaving an institution.